COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to In-Network benefits. Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. With respect to an Employee or Dependent, coverage of the Employee or Dependent under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help a Member meet a Member's routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.
Even if a Member is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

DEPENDENT. Your:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of the Contract.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by the Contract as an Employee.

At Our Discretion, We can require proof that a person meets the definition of a Dependent.

DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) Your Eligibility Date; or
b) the date the person first becomes a Dependent.

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests

With respect to Out-of-Network benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a Member in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Contract for a Member.

EMPLOYEE. A Full-Time paid Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment; or
b) the day after any applicable waiting period ends.

EMPLOYER. The company identified on the Application for a Small Employer Health Benefits Policy.

ENROLLMENT DATE. With respect to a Member, the Effective Date or, if earlier, the first day of any applicable waiting period.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies. We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

a) The American Medical Association Drug Evaluations;
b) The American Hospital Formulary Service Drug Information; or
c) The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or

more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

FACILITY. A place which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Contract.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. ' 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance

organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited as a hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or

part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member.

INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.

INJURY. Damage to a Member's body, and all complications arising from that damage.

INPATIENT. Member, if physically confined as a registered bed patient in a Hospital or other health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee or Dependent who requests enrollment under the Contract more than 31 days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage and Dependent Coverage subsections of the **Eligibility** section of the Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include but are not limited to heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We Determine to be:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a Member's convenience;
e) the most appropriate level of medical care that a Member needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, with respect to In-Network services and supplies, and in all instances with respect to Out-of-Network benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under the Contract (includes Covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, including Substance Abuse, regardless of any underlying physical cause. As used in the Contract a Mental or Nervous Condition does not include a Biologically-based Mental Disorder, or Alcohol Abuse, as defined in the Contract.

In Determining whether or not a particular condition is a Mental or Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence. For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifiests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based. In determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

NON-COVERED CHARGES. Charges which do not meet the Contract's definition of Covered Charges or which exceed any of the benefit limits shown in the Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by the Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in the Contract.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Contract.

OUT-OF-NETWORK PROVIDER. A Provider which is not a Participating Provider.

OUTPATIENT. Member, if not confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PARTICIPATING PROVIDER. A Provider which has an agreement directly or indirectly with Us to provide Covered Services or Supplies.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PER LIFETIME. During the lifetime of an individual, regardless of whether he or she was covered under the Contract or any other contract, policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption of coverage.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. ' 1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Contract.

PRE-APPROVAL or PRE-APPROVED. Our written approval for specified services and supplies prior to the date the charges are incurred. Services or supplies for which the charges have not been pre-approved are not covered.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the Member's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the

Member's diagnosis or condition in one or more of the following established reference compendia:
- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A Participating Practitioner who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to In-Network services and supplies, the negotiated arrangement. With respect to Out-of-Network benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the Out-of-Network benefits under the Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area. ★

REFERRAL. With respect to In-Network services or supplies, specific direction or instruction from a Member's Primary Care Physician in conformance with Our policies and procedures that directs a Member to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences,

helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to In-Network services and supplies, the geographic area We define by county. The Service Area is all counties of New Jersey.

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

SPECIAL CARE UNIT. A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine, pediatrics or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females.

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does not include abuse of or addiction to alcohol. Please see the definition of Alcohol Abuse.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as surgery.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy - the introduction of dry or moist gases into the lungs.

Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in the Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.

WE, US, OUR. Physicians Health Services of New Jersey, Inc ("PHS") and its affiliates.

YOU, YOUR, AND YOURS. The Employee.

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees who are in an eligible class will be eligible if the Employees are Full-Time Employees.

For purposes of the Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement
We will not cover an Employee unless the Employee is a Full-Time Employee.

Enrollment Requirement
We will not cover You until the You enroll and agree to make the required payments, if any. If You do this within 31 days of Your Employee's Eligibility Date, coverage will start on Your Employee's Eligibility Date.

If You enroll and agree to make the required payments, if any:

a) more than 31 days after Your Employee's Eligibility Date; or
b) after You previously had coverage which ended because You failed to make a required payment;

We will consider You to be a Late Enrollee. Late Enrollees are subject to the Contract's Pre-Existing Conditions limitation.

When You initially waive coverage under the Contract, the We should notify You of the requirement for the Employee to make a statement that waiver was because You were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If You initially waived coverage under the Contract and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under the Contract, We will not consider You and Your Dependents to be Late Enrollees, provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation;
e) death of Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll under the Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under this Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee and any Dependents will not be considered Late Enrollees if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.

The Waiting Period
The Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed the specified number of months of continuous Full-Time service with the Employer by that date, as determined by the Employer and as specified in Item 12 of the Application for a Small Employer Health Benefits Policy but not to exceed 6 months, are eligible for coverage under the Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed the specified number of months of continuous Full-Time service with the Employer by that date, as determined by the Employer and as specified in Item 12 of the Application for a Small Employer Health Benefits Policy but not to exceed 6 months, are eligible for coverage under the Contract from the day after Employees complete the specified number of months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under the Contract from the day after Employees complete the specified number of months of continuous Full-Time service with the Employer as determined by the Employer and as specified in Item 12 of the Application for a Small Employer Health Benefits Policy but not to exceed 6 months.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier. You may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Contract's eligibility waiting period if:
a) You were employed by the Employer on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Multiple Employment
If You work for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Contract. But, if the Contract uses the amount of an Employee's earnings to determine class, or for any other reason, such Employee's earnings will be figured as the

sum of his or her earnings from all covered Employers.

When Employee Coverage Starts
You must be working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments if any, within 31 days of Your Employee's Eligibility Date. If You do this within 31 days of Your Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of Your coverage.

If You do this more than 31 days after Your Employee's Eligibility Date, We will consider You a Late Enrollee. Coverage is scheduled to start on the date You sign the enrollment form.

When Employee Coverage Ends
Your coverage under the Contract will end on the first of the following dates:

a) the date You cease to be a Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) the date You stop being an eligible Employee under the Contract.
c) the date the Contract ends, or is discontinued for a class of Employees to which You belong.
d) the last day of the period for which required payments have been made for You, subject to the **Payment of Premium - Grace Period** section.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. The Contract's benefits provisions explain these situations. Read the Contract's provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are:

a) Your legal spouse;
b) Your unmarried Dependent children who are under age 19; and
c) Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Eligible Dependents will not include any Dependent who is:

a) covered by the Contract as an Employee or
b) on active duty in the armed forces of any country.

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, Your step-children if they depend on You for most of their support and maintenance and children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past the Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached the Contract's age limit;
b) the child became covered under the Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Contract. We consider an eligible Dependent to be a Late Enrollee, if You:

a) enroll a Dependent and agree to make the required payments more than 31 days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Contract's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When You initially waive coverage for a spouse and/or eligible Dependent children under the Contract, We should notify You of the requirement for You to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement.

If You previously waived coverage for Your spouse or eligible Dependent children under the Contract and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation;
e) death of the Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, We will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Contract, to be a Late Enrollee, if:

a) You are under legal obligation to provide coverage due to a court order; and
b) You enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

In addition, if an Employee initially waived coverage under this Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts

In order for Your Dependent coverage to begin, You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Contract, the date Your Dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date You become covered for Employee coverage.

If You do this more than 31 days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date You sign the enrollment form; or
b) the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within the 31 days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child or newly adopted child will be covered from the later of:
a) the date You notify Us and agree to make any additional payments, or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Contractholder who purchased the replacement Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date the replacement Contract takes effect will initially be eligible for limited coverage under the replacement Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the replacement Contract takes effect immediately upon termination of the prior plan.

The coverage under the replacement Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the replacement Contract will end one year from the date the person's coverage under the replacement Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the replacement Contract.

Newborn Children
We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:
a) If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid, and, in order to access In-Network services and supplies, You must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.
b) If You are not covered for Dependent child coverage on the date the child is born, You must:
   1) make written request to enroll the newborn child; and
   2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends

A Dependent's coverage under the Contract will end on the first of the following dates:

a) the date Your coverage ends;
b) the date You stop being a member of a class of Employees eligible for such coverage;
c) the date the Contract ends;
d) the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
e) the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.
f) At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read the Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.

EXTENDED HEALTH BENEFITS

If the Contract ends and a Member is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the Member.

We will only extend benefits for a Member due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies, or charges incurred by other family members. The extension ends on the earliest of:

a) the date the Total Disability ends;
b) one year from the date the person's coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

You must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under the Contract:

Untenable Relationship: After reasonable efforts, We and/or Participating Providers are unable to lish and maintain a satisfactory relationship with the Member or the Member fails to abide by our regulations, or the Member acts in a manner which is verbally or physically abusive.

f Identification Card: The Member permits any other person who is not authorized by Us tification Card We issue to the Member.

orrect or Incomplete Information: The Member furnishes incorrect or incomplete atement made for the purpose of effecting coverage under the Contract. This

condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The Member fails to pay any Copayment or Coinsurance or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The Member abuses the system, including but not limited to; theft, damage to Participating Provider's property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the Member such written notice:
a) that person will cease to be a Member for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the Member under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

MEMBER PROVISIONS: APPLICABLE TO IN-NETWORK SERVICES AND SUPPLIES

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and the Customer Service department within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

THE ROLE OF THE CASE MANAGER. The Case Manager will manage a Member's treatment for a Biologically-based Mental Illness, a Non-Biologically-based Mental Illness, Substance Abuse, or Alcohol Abuse. A Member must contact the Case Manager or the Member's Primary Care Physician when a Member needs treatment for one of these conditions.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN

When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician.

Members select a Primary Care Physician from the PHS Directory of Physicians and Providers; this choice is solely a Member's. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection. If a Member fails to select a Primary Care Physician, We will make a selection on behalf of the Member.

After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The Member can select another Primary Care Physician from the PHS Directory of Physicians and Providers.

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If We receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to the Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under the Contract, and misuse of such Identification Card constitutes grounds for termination of Member's coverage. If You are the Member who misuses the card, coverage may be terminated for You as well as any of Your Dependents who are Members. To be eligible for services or benefits under the Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under the Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of the Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to the Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us, may not be disclosed without the Member's written consent, except as required or authorized by law.

INABILITY TO PROVIDE IN-NETWORK SERVICES AND SUPPLIES

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under the Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under the Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Except in the case of a Medical Emergency, a Member will not be eligible for any In-Network services provided by anyone other than a Member's Primary Care Physician (including but not limited to Specialist Services) if a Member has not been referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the Member's Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Practitioner. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Practitioner. If such Participating Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Practitioner shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during

the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding position of the Participating Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate this Contract in accordance with the General Provisions. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the Participating Practitioner will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a Member, such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us, upon request, and to permit copying of a Member's records by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with In-Network benefits, We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by the PHS Medical Director. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under the Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

a) No Participating Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other Provider, institution, Facility or agency.
b) Neither the Contractholder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under the Contract.
c) Participating Practitioners maintain the physician-patient relationship with Members and are solely responsible to Members for all medical services which are rendered by Participating Practitioners.
d) No Contractholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

COVERED SERVICES AND SUPPLIES *APPLICABLE TO IN-NETWORK SERVICES AND SUPPLIES*

Members are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable Copayments or Coinsurance as stated in the applicable Schedule.

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office selected by a Member, or elsewhere upon prior Referral by a Member's Primary Care Physician.

1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Home visits** by a Member's Primary Care Physician.
3. **Periodic health examinations** to include:
   A. Well child care from birth including immunizations;
   B. Routine physical examinations, including eye examinations;
   C. Routine gynecological exams and related services;
   D. Routine ear and hearing examination; and
   E. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a Member's Primary Care Physician and approved in advance by Us.
7. **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in the Contract.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of the Contract.
9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
10. **Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a Participating Provider.

    A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the Member's Participating Provider.

    A supply will be considered to be furnished at the time the Prescription Drug is received.
11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Member's Primary Care Physician and approved in advance by Us.

12. **Dental x-rays** when related to Covered Services.
13. **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases:** We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a Member's Practitioner.

    For the purpose of this benefit:

    "inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;

    "low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
    "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a Participating Specialist Doctor at the Practitioner's office or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior Referral by a Member's Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior Referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Facilities (or at Non-Participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Member, in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

- As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
  - a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and
  - a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.
- We provide such coverage subject to the following:
  - the attending Practitioner must determine that inpatient care is medically necessary;

or

- the mother must request the inpatient care.

- As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.

2. Private accommodations will be provided only when approved in advance by Us. If a Member occupies a private room without such approval Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.
23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND NON-BIOLOGICALLY-BASED MENTAL ILLNESSES.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center upon prior Referral by a Member's Primary Care Physician. This section does not address coverage for a Biologically-based Mental Illness.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and

Non-Biologically-based Mental Illnesses. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging one or more of the inpatient hospital days described in paragraph 2 below where each exchanged inpatient day provides two outpatient visits.

2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Non-Biologically-based Mental Illnesses. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that Members have been cooperative with an on-going treatment plan. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate, and only to the extent of the covered benefit as defined above.

NOTE: ANY SUBSTANCE ABUSE AND NON-BIOLOGICALLY-BASED MENTAL ILLNESSES BENEFITS A MEMBER RECEIVES AS OUT-OF-NETWORK BENEFITS WILL REDUCE THE BENEFITS AVAILABLE AS IN-NETWORK NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE SERVICES AND SUPPLIES.

(e) **BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS OR ALCOHOL ABUSE.** We cover treatment of a Biologically-based Mental Illness or Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Participating Provider upon prior written referral by a Member's Primary Care Physician. We do not pay for Custodial care, education or training.

(f) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a Member's Primary Care Physician in the event of a Medical Emergency as Determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician or Us prior to seeking emergency treatment.
2. We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior Referral only if:
   A. Our review Determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention.
   B. The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-emergency basis; and

C. We and a Member's Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We Determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event Members are hospitalized in a Non-Participating Facility, In-Network coverage will only be provided until Members are medically able to travel or to be transported to a Participating Facility. If Members elect to continue treatment with Non-Participating Providers, We shall have no responsibility to continue to provide coverage on an In-Network basis for services and supplies beyond the date Members are Determined to be medically able to be transported. The Member may be eligible for Out-of-Network benefits, subject to the terms and conditions of the Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided upon prior Referral to a Participating Provider.

4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or Members shall be responsible for payment.

5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(g) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Practitioner upon prior Referral by a Member's Primary Care Physician.

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy and Respiration Therapy.

NOTE: ANY THERAPY BENEFITS A MEMBER RECEIVES AS A OUT-OF-NETWORK COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS IN-NETWORK THERAPY SERVICES AND SUPPLIES.

(h) **HOME HEALTH SERVICES.** The following services are covered when rendered by a Participating Provider including but not limited to a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.

1. **Skilled nursing services,** provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide,** under the supervision of a registered professional nurse,

or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.

3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if Members are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the Member's Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our Determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

(i) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a Participating Practitioner upon prior Referral by a Member's Primary Care Physician. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury occurs while the Member is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a Member who is severely disabled or who is a Child under age 6, We cover:

a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

(j) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a Participating Practitioner upon prior Referral by a Member's Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(k) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a Participating Practitioner upon prior Referral by a Member's Primary Care Physician. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS MEMBER RECEIVES AS OUT-OF-NETWORK COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS IN-NETWORK THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

OUT-OF-NETWORK BENEFIT PROVISION *APPLICABLE TO OUT-OF-NETWORK BENEFITS*

The Cash Deductible
Each Calendar Year, each Member must have Covered Charges that exceed the Cash Deductible before We pay any Out-of-Network benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the Member while covered by the Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by the Contract. And what We pay is based on all the terms of the Contract.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:

a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the Calendar Year in which the Contract starts;
b) the charges would have been considered Covered Charges under the Contract if the Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

Family Deductible Limit
The Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Members in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any Member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of the Contract.

Coinsured Charge Limit
The Coinsured Charge Limit is the amount of Covered Charges a Member must incur each Calendar Year before no Coinsurance is required, **except as stated below.**

Exception: Charges for Non-Biologically-based Mental Illnesses, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

COVERED CHARGES *APPLICABLE TO OUT-OF-NETWORK BENEFITS*

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of the Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced or eliminated if a Member does not comply with the Utilization Review and Pre-Approval requirements contained in the Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to Member by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Member during the Inpatient Confinement.

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Member, in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:

a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.

If a Member incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to the Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. The Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of the Contract.

Emergency Room Copayment Requirement
Each time a Member uses the services of a Hospital emergency room, he or she must pay a $50.00 Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges
We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Member's health.

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Member on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a Member during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered. But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A MEMBER RECEIVES AS A IN-NETWORK SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A OUT-OF-NETWORK COVERED CHARGE.

Home Health Care Charges:
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a Member under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals; and

i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Contract and to the following conditions:

I. The Member's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
   A. ordered by the Member's Practitioner;
   B. included in the home health care plan: and
   C. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

II. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

III. The home health care plan must be set up in writing by the Member's Practitioner within 14 days after home health care starts. And it must be reviewed by the Member's Practitioner at least once every 60 days.

IV. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

V. We do not pay for:
   A. services furnished to family members, other than the patient; or
   B. services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

Practitioner's Charges for Non-Surgical Care and Treatment

We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Practitioner's Charges for Surgery

We cover Practitioner's charges for Medically Necessary and Appropriate Surgery. We do not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges

We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a Member is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Member under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Member's terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the Member's Practitioner has certified in writing that the Member's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Member. It must be set up and reviewed periodically by the Member's Practitioner.

Under a Hospice care program, subject to all the terms of the Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Contract. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Member's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

Alcohol Abuse
We pay benefits for the Covered Charges a Member incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training. Treatment may be furnished by:

a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Treatment for Biologically-based Mental Illness
We pay benefits for the Covered Charges a Member incurs for the treatment of Biologically-based Mental Illness the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. We do not pay for Custodial Care, education, or training.

Pregnancy
The Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained below.

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Member's pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Member by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A MEMBER RECEIVES AS AN IN-NETWORK SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS AN OUT-OF-NETWORK COVERED CHARGE.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But We do not pay for replacements or repairs.

Blood
We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Member.

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a Member to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Member to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) any purchases without Our advance written approval;
b) replacements or repairs; or
c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Member. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of the Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

Food and Food Products for Inherited Metabolic Diseases
We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the Member's Practitioner. For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO OUT-OF–NETWORK BENEFITS*

Dental Care and Treatment
We cover:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury occurs while the Member is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a Member who is severely disabled or who is a Child under age 6, We cover:

a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices
We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of the Contract.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

Mammogram Charges
We cover charges made for mammograms provided to a female Member according to the schedule given below. Benefits will be paid, subject to all the terms of the Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female Member, ages 35 - 39
b) one mammogram, every 2 years, for a female Member, ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female Member ages 50 and older.

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

We cover the following Therapy Services:
Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

We cover the Therapy Services listed below, subject to stated limitations:

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A MEMBER RECEIVES AS IN-NETWORK THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A OUT-OF-NETWORK COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

Preventive Care
We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography , screening tests and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:

a) $500 per Member for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per Member for all other Members.

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A MEMBER RECEIVES AS A IN-NETWORK SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A OUT-OF-NETWORK COVERED CHARGE.

Immunizations and Lead Screening
We will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Vision Screening
We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS IN-NETWORK SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A OUT-OF-NETWORK COVERED CHARGE.

Non-Biologically-based Mental Illnesses and Substance Abuse
We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse as those terms are defined in the Contract.

A Member may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker.

The Member must pay the Coinsurance shown on the Schedule for such treatment. We limit coverage for all treatment of Non-Biologically-based Mental Illnesses and Substance Abuse per Calendar Year to:

a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.

One or more of any unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.
We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND NON-BIOLOGICALLY-BASED MENTAL ILLNESSES SERVICES AND SUPPLIES A MEMBER RECEIVES AS IN-NETWORK SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A OUT-OF-NETWORK COVERED CHARGE.